USMLE-STEP-3 Q&As

United States Medical Licensing Step 3

Pass USMLE USMLE-STEP-3 Exam with 100% Guarantee

Free Download Real Questions & Answers **PDF** and **VCE** file from:

https://www.passapply.com/usmle-step-3.html

100% Passing Guarantee
100% Money Back Assurance

Following Questions and Answers are all new published by USMLE Official Exam Center

- **Instant Download** After Purchase
- **100% Money Back** Guarantee
- **365 Days** Free Update
- **800,000+** Satisfied Customers

QUESTION 1

A 60-year-old morbidly obese man presents with complaints of fatigue, worsening exertional dyspnea, three-pillow orthopnea, lower extremity edema, and cough occasionally productive of frothy sputum. He has a long-standing history of type II diabetes and hypertension. On examination, you note the presence of bibasilar rales, an S3 gallop, jugular venous distention, and 2+ pitting edema in both legs up to the knees. There does not appear to be an arrhythmia present. Which of the following has been shown to prolong survival in patients with this condition?

A. digoxin

B. nonsteroidal anti-inflammatory drugs(NSAIDs)

C. warfarin

D. carvedilol

E. diltiazem

Correct Answer: D Section: (none)

Explanation:

This patient\\'s presentation is most consistent with pulmonary edema from decompensated CHF. The BNP test has been found to be both sensitive and specific for the diagnosis of CHF. It can be a very useful test to order when a patient is dyspneic to help to determine if CHF is the cause. Troponin, CK-MB, and LDH are markers of damage to cardiac muscle and can be diagnostic in a MI. While MI can be a cause of CHF, and most patients presenting with CHF will have cardiac enzymes drawn as part of their evaluation, cardiac enzymes are neither sensitive nor specific for CHF. Similarly, a CXR can determine the presence of pulmonary edema but not its cause.

Acute pulmonary edema secondary to CHF will require management with diuresis for acute symptomatic relief. ACE inhibitors and beta-blockers do decrease mortality and morbidity in CHF; however their use in acute decompensated heart failure is suspected as they may induce hypotension and further cardiogenic shock. Digoxin is used for symptomatic relief either when other modalities fail or when rate control from atrial fibrillation is an issue. In patients with CHF and atrial fibrillation, beta-blockers have shown better effect and reduced morbidity than digoxin. Nevertheless, in the acute setting of decompensated heart failure with pulmonary edema, diuresis is the optimal initial treatment, not digoxin. In chronic heart failure, digoxin is reserved for patients with systolic failure that are symptomatic despite adequate ACE inhibitor and beta-blocker use. Furosemide is effective in treating the acute pulmonary edema associated with CHF by virtue of its potent diuretic action, which rapidly eliminates excess body fluid volume.

QUESTION 2

You are called to see a newborn in the nursery because the nurse is concerned that the baby may have

Down syndrome.

The infant begins to have progressively large amounts of bilious emesis. The infant feeds well and has only

a small amount of abdominal distention.

What is the most likely diagnosis?

A. pyloric stenosis

B. Hirschsprung disease

C. biliary atresia

D. duodenal atresia

E. milk protein allergy

Correct Answer: D Section: (none)

Explanation:

The most common finding in a newborn with Down syndrome is hypotonia. Other common findings include single palmar crease, flat facial profile, macroglossia, and wide space between the first and second toes. Hypotonia in the newborn period should prompt close evaluation and follow-up. Café au lait spots are associated with neurofibromatosis. High arched palates are associated with fragile X syndrome. Ambiguous genitalia are commonly seen in CAH.

Children with Down syndrome are at an increased risk for hypothyroidism. It may be hard to detect without routine laboratory screening as they will commonly have mental retardation and developmental delay as part of their syndrome. Hypothyroidism may not be present in the immediate newborn period and requires, at a minimum, annual testing throughout the child\\'s life. The other findings listed are not specifically associated with Down syndrome. Lens dislocation is commonly found with Marfan syndrome or homocysteinuria.

Children with Down syndrome have an increased prevalence of duodenal atresia. Pyloric stenosis is uncommon to see in the newborn period. It tends to present with nonbilious vomiting usually after 24 weeks of age. Hirschsprung disease (aganglionosis coli) presents with constipation and failure to pass stool. Infants with Hirschsprung disease commonly will not pass stool in the first days of life. Biliary atresia is a progressive cause of jaundice in an infant. It is the most common cause of a cholestatic jaundice in the newborn period. Emesis is not typically associated with biliary atresia. Milk protein allergy is a common cause of bloody stools in the first few months of life, but does not have bilious emesis associated with it.

QUESTION 3

An 82-year-old woman schedules an appointment to see you for neck and back pain. At age 50, she had an L4-L5 diskectomy and laminectomy. She also has long-standing hypothyroidism for which she takes levothyroxine 0.1 mg daily. Over the past few months, she has become more fatigued and describes pain in both of her arms, her low back, and the front of her thighs. She notes that the tops of her shoulders are also achy. She decided to call for an appointment because of worsening headache. She tells you that she has an appointment later this afternoon with her ophthalmologist, because she noticed some flickering of the vision in her left eye. Upon further questioning, she does acknowledge that she has cut her telephone conversation short with her daughter because her jaw begins to ache if she talks too long. Physical examination shows that she has normal vital signs. She has diffuse scalp tenderness. The oral mucosa is normal without aphthous ulcers and the salivary pool is normal. Her pupils are equal, round, and reactive to light and accommodation, and extraocular muscles are intact. The funduscopic examination appears normal for her age. Neck motion is slightly reduced to lateral flexion and rotation. Her trapezii are tender to palpation, but there is no significant loss of range of motion in her shoulders. Her supraspinatus and infraspinatus tendons appear intact. Her quadriceps are mildly tender, but her gastrocnemius muscles are normal. Her strength is normal for age. Her reflexes are normal and symmetrical.

Which of the following should be done next?

A. start 80 mg prednisone daily

B. start ibuprofen and refer for a temporal artery biopsy

C. trigger point injections of triamcinolone in the trapezius muscles

D. stat MRI/MRA of the head

E. no treatment until after she is evaluated by the ophthalmologist and a rheumatologist

Correct Answer: A Section: (none)

Explanation:

The diagnosis is almost certainly temporal arteritis. Age over 70, headache with scalp tenderness, jaw claudication, and visual disturbance would suggest the diagnosis even if the sedimentation rate came back within the normal range. Since the patient\\'s supraspinatus and infraspinatus strength are normal, complete rotator cuff tear seems unlikely. Rotator cuff tears would also not explain the leg component. Osteoarthritis of the neck and back could explain many of her clinical features, particularly if spinal stenosis is present, but would not account for the jaw claudication or the headaches with scalp tenderness. Many patients with temporal arteritis have features of polymyalgia rheumatica, but in this case, temporal arteritis is the best working diagnosis. Temporal arteritis is one of the few unequivocal rheumatic disease emergencies. The patient should be given large doses of prednisone immediately. An ESR should be obtained, but as noted above, even a normal study would not prevent the prednisone from being prescribed at this point. You should also contact the ophthalmologist because there can be retinal clues not picked up on standard office funduscopy. In addition, many ophthalmologists now will do the temporal artery biopsy in their patients. This is a very reasonable next step for the patient and will unequivocally establish the diagnosis.

Temporal arteritis may have skip lesions, and thus, a fairly significant length of the temporal artery should be taken by the surgeon. MRI of the brain, even with MRA, will not help establish a diagnosis of temporal arteritis and will needlessly delay diagnosis, possibly causing the patient to lose vision.

QUESTION 4

A 50-year-old male presents to your office after reading an article on the Internet stating that a recent study showed that the drug finasteride can prevent prostate cancer. He asks you to prescribe this medication for him. You review the article and find the following information: a randomizedcontrolled trial of men over the age of 55 with normal prostate-specific antigen (PSA) readings was performed comparing finasteride and a placebo. At the end of the study, 18% of the men in the finasteride group and 24% of the men in the placebo group had developed prostate cancer.

How many men need to be treated with finasteride to prevent one case of prostate cancer (NNT)?

A. 6

B. 10

C. 17

D. 24

E. 32

Correct Answer: C Section: (none)

Explanation: Explanations: The NNT is calculated by first determining the ARR for a specific outcome between two groups in a study. The ARR, or risk difference, is calculated by subtracting the percentage of subjects who develop an outcome in the treatment group from the percentage who develop the outcome in the control group. In question 35, the outcome considered is the development of prostate cancer. This occurred in 24% of the control group and 18% of the finasteride group. The ARR is calculated as 24% -18% = 6% or

0.06. The NNT is calculated as: NNT = 1/ARR. In this example, the NNT = 1/0.06 = 16.67, approximately 17. This suggests that for every 17 men who took finasteride there was one fewer case of prostate cancer. The NNH is calculated in exactly the same manner as the NNT. The only difference is that the outcome is adverse. In this study, highgrade prostate cancers occurred more often in the finasteride group than the placebo group; 6.4% of men who took finasteride and 5.1% who took a placebo developed high-grade prostate cancer. The risk difference, in this case an absolute risk increase, is 6.4% -5.1% = 1.3% or 0.013. The NNH = 1/absolute risk increase = 1/0.013 = 77

QUESTION 5

A 48-year-old woman complaining of dysuria is diagnosed with a UTI by urinalysis. Urine culture and sensitivities reveal that the causative organism belongs to the genus Klebsiella and is resistant to multiple antibiotics. Based upon the results available, you decide to begin therapy with gentamicin.

Which of the following would lead to the classification of this patient\\'s infection as "complicated?"

A. a history of recurrent UTIs

B. a diagnosis of type II DM

C. the patient\\'s gender

D. a history of undergoing a laparoscopic appendectomy 1 month ago

E. a postvoid residual volume of 25 cc

Correct Answer: B Section: (none)

Explanation:

Aminoglycosides such as gentamicin accumulate in the proximal tubular cells of the kidney, resulting in a defect in renal concentrating ability and reduced glomerular filtration after several days. This renal impairment is almost always reversible. Of all the aminoglycosides, gentamicin and tobramycin are the most nephrotoxic. Aminoglycosides may also cause ototoxicity in the form of irreversible auditory or vestibular damage. There is a direct relationship between aminoglycoside dosage and the risk for development of ototoxicity, so doses should be adjusted according to a patient\\'s baseline renal function. Complicated UTIs involve metabolic or hormonal abnormalities such as those seen in M or during pregnancy; the presence of foreign bodies such as calculi, tumors, or catheters; the presence of strictures causing turbulent urine flow or vesicoureteral reflux; incomplete voiding such as that seen in neurogenic bladder, prostate hyperplasia or cancer; and, the presence of unusual infecting microorganisms. A history of recurrent UTI does not in itself lead to the classification of subsequent infections as complicated. Due to anatomic differences in urethral length between males and females, any UTI in a male is considered complicated. A history of recent surgery does not correlate with development of a complicated UTI unless the surgical procedure resulted in the creation of some anatomic abnormality which increased the risk of infection; examples of such abnormalities include adhesions or strictures. Apostvoid residual volume greater than 50100 mL suggests abnormal bladder emptying, which would predispose an individual to development of UTIs.

USMLE-STEP-3 PDF Dumps
USMLE-STEP-3 VCE Dumps
USMLE-STEP-3 Braindumps